The Medical Approach and the Social Approach to Disability:

A Descriptive Analysis

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DECLARATION

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

…… ……

Christian John Mauri Date

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ABSTRACT

The thesis offers a descriptive analysis of how the “medical approach” to disability and the “social approach” to disability understand and analyse disability as an area of inquiry. The medical approach treats disability as a pathological, deviant state caused by biological and physiological dysfunctions. This approach is discussed in regard to medical sociology, which treats disability primarily as a form of social deviance, and the individual model, which uses medical language to categorise disability based on functional limitations. The social approach treats disability as a social issue, with social forces influencing experiences of disability. This approached is used within disability studies, which argues that disabled individuals represent an oppressed social group, and the social model, which distinguishes between “impairment” and “disability” in order to treat disability as a social entity characterised by a range of social and material conditions.

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Christian

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CHAPTER 1 – Introduction

The thesis examines two approaches to understanding and analysing disability. The first approach discussed is the "medical approach", which treats disability as a pathological, deviant state that is confined to the individual. In discussing this approach the thesis offers a description of medical sociology, which treats disability primarily as a form of social deviance, and the individual model of disability, which uses medical understandings and categories. The second approach discussed is the "social approach", which treats disability as a social issue, with social forces exacerbating or reducing experiences of disability. In discussing this approach the thesis describes disability studies, which adopts a critical analysis of the social oppression of disabled individuals, and the social model of disability, which is characterised by a distinction between "disability" and "impairment".

Disability as an Area of Inquiry

The area of inquiry that is disability is comprised of a variety of approaches that understand, describe, and analyse disability in different ways. This means that, rather than there being a single, overarching description of "disability", the term can mean different things depending on what approach is being adopted. Furthermore, there is no common point from which it can be studied as an area of inquiry, with each approach using different modes of analysis that may focus on a range of aspects of disability, such as its medical or social characteristics, its

economic or political implications, or its nature as a historically specific effect of power/knowledge (Tremain 2001, 617).

It therefore seems appropriate to begin the thesis by acknowledging that the medical approach and the social approach to disability represent just two ways in which disability may be understood and analysed. This is not to understate their importance as distinct approaches that are worth consideration; indeed, the thesis demonstrates that these two approaches offer very different understandings of disability that have been influential in informing the manner in which it is approached as an area of inquiry. Nevertheless, it remains that there is a wealth of material dealing with disability that, although not dealt with in the thesis, represent a growing range of relevant understandings and approaches.

For example, there has been a growing amount of material advocating the development of a "sociology of disability" (Kutner 2007; Thomas 2007; Williams 1998). Such a field would treat disability as a social issue, analysing the social relations and social forces that construct, produce, and institutionalise disability, as well as the ways in which these forces influence the lived experience of disability (Thomas 2007, 181-2). In so doing, the field would attempt to claim for disability what sociology has claimed for age, gender, race, and social class (Zola 1991).

However, this field has been slow to develop, owing to the lack of a unifying theory or perspective (Barnes *et al*. 1999, 211; Williams 2001, 130). This has led to diversity in accounts of how the sociology of disability should develop and what its priorities should be. For example, Thomas (2007, 181) argues that the field should adopt a "social oppression" paradigm, informed by the critical analysis offered by disability studies, which will be discussed in Chapter Three. Hughes and Paterson (2010, 326-30), on the other hand, argue that disability studies pays too little attention to the body, and that a "sociology of impairment", which would focus on the embodied experience of impairment and disability, would be more appropriate.

Another development that is relevant to the way in which disability is treated as an area of inquiry is the increasing interest and diversity in "social construction" accounts. In this context, disability is approached not as a biological or physiological issue, but rather as a body of knowledge that may be constructed, produced, reproduced, and challenged in a variety of ways. As such, disability as an area of inquiry may be located in a range of wider social values, ideas, and contexts (Cocks *et al*. 1996, 284)

This understanding has been embraced in different ways within the disability literature, with Hughes and Paterson (2010) advocating a phenomenological analysis of disability that emphasises the different ways in which disability may be felt as a "lived experience". Rapley (2004) deals with the ways in which

intellectual disability is constructed in a clinical setting, focusing in particular on the role of clinical psychology. Tregaskis (2004) looks at the ways in which disability is negotiated in the social interactions between disabled and non-disabled individuals.

Although these arguments are not considered in the thesis, they, along with the medical approach and the social approach, reflect the size and complexity that characterise disability as an area of inquiry. This complexity is noted by Williams (1998, 241-2), who argues that:

> Disability is fundamentally a problem of representation in a number of senses: there is no language to talk about it that is untainted; the language and categories we use influence the definition and measurement of 'the problem'; and there is continuing dispute about who are the legitimate representatives of the experience and reality of disability in the modern world.

This variety in representation and language is central to disability, with no understanding or discussion relating to this area of inquiry being entirely neutral, a point that the thesis demonstrates.

On Terminology and Method

In using the terms "medical approach" and "social approach" the thesis is referring to two different ways in which disability may be understood and

analysed as an area of inquiry. The term “approach” is used because they are just that: approaches to the broad area of knowledge that is disability. As such, it should not be assumed that either approach offers the final word on disability or some distinct way of understanding the subject matter that is inherently correct by nature. Furthermore, while the thesis describes these approaches as separate entities, this does not mean that they may not overlap and inform one another in different ways, as the description of medical sociology will show.

While the term “medical approach” was chosen due to its straight forward referral to the medical understandings and practices that make it up, there is more to this approach than medicine. As the thesis will show, the medical approach has two central characteristics: the tendency to treat disability as a pathological state, and the tendency to treat disability as a form of social deviance. Thus, the approach has important sociological implications that may not be evident in its title. Nevertheless, the title “medical approach” seems appropriate over other titles[1] as it captures the approach’s foundations in medicine whilst distinguishing it nicely from the social approach.

The term “social approach” was chosen as the most accurate description of a particular way of understanding and analysing disability as a social issue. This approach is related to disability studies and the social model, being the reasoning

[1] Originally the term “traditional approach” was used instead of “medical approach”. However, this was too ambiguous and invoked the language of disability studies in a manner that risked compromising the balance of the thesis.

behind arguments relating to the social oppression of disabled individuals, and the need for a re-examination of the language that is often used to discuss disability. Indeed, this relationship is so close that the term “disability studies” was initially used in place of “the social approach”. However, as the approach is the method that informs the arguments of disability studies, it seemed appropriate to change this. At any rate, it is evident throughout Chapter Three that this distinction is one of clarity, rather than theoretical difference.

The thesis is one of scholarly interest, not advocacy. In other words, the thesis does not argue for or against the medical approach, the social approach, or the fields and models that are used to exemplify them. While Chapter Three contains a number of criticisms of the understandings described in Chapter Two, this is because the arguments of the social approach are relatively new, being built on a critical analysis of its predecessor. In contrast, the medical approach has been a dominant authority on disability since the beginning of the twentieth century and has yet to offer a concentrated response within the academy to the social approach. Thus, while the thesis grants more discussion to the criticisms levelled against the medical approach than the social approach, this is not a way of advocating one approach over another; rather, it is a necessary part of the descriptive analysis with which the thesis is concerned.

In offering this descriptive analysis the thesis has been informed by the description of sociological thinking offered by Bauman (1990). In this description

Bauman lists four traits that characterise sociological thought: *Responsible speech, size of the field, making sense,* and *defamiliarisation*. *Responsible speech* emphasises the sociologist's responsibility to take great care in distinguishing between statements informed by available evidence and statements informed by personal beliefs (Bauman 1990, 12). In regard to this trait the information offered in this thesis is the result of the careful collection of information on the approaches, fields, and models to be discussed based on the references given. None of the arguments within the thesis are based on personal belief and as such the thesis makes no normative claims.

An acknowledgment of the *size of the field* is necessary in order to recognise that there is a tremendous variety of information, conditions, and fields of study that are available to the sociologist (Bauman 1990, 12-13). If just one approach or field of study is used in analysing an area of inquiry then the information gathered is likely to be one-sided. This is why the thesis is concerned with analysing and describing two approaches to disability, placing two different sets of understandings and practices next to one another, along with the fields that they have influenced, in order to show the variety that exists in the area of inquiry that is disability.

The manner in which the sociologist goes about *making sense* of the information gathered is the third important trait discussed by Bauman (Bauman 1990 13-14). Rather than beginning their analysis as it relates to individual actors or actions, the sociologist begins with a focus on "figurations" or networks of dependencies.

The figurations that are observed in the thesis are the approaches, fields and models being discussed and the networks of understandings, arguments and practices that make them up. Suffice to say, these figurations are the "characters" of the thesis, while the aim of the thesis is to make sense of these characters by describing their understandings, arguments, and practices.

Finally, an important task of the sociologist is to *defamiliarise* what is often taken for granted (Bauman 1990, 15). This last trait is most adequately described by Bauman, who argues that (Bauman 1990, 15):

> Familiarity is the staunchest enemy of inquisitiveness and criticism – and thus also of innovation and the courage to change. In an encounter with that familiar world ruled by habits and reciprocally reasserting beliefs, sociology acts as a meddlesome and often irritating stranger. … Suddenly, the daily way of life must come under scrutiny. It now appears to be just one of the possible ways, not the one and only, not the 'natural', way of life.

The descriptive analysis offered in the thesis takes a number of understandings of disability that are often taken for granted within their own respective approaches, fields, and models, and places them next to one another. By providing this information in such a way, the thesis shows how such understandings are just a few among many. Furthermore, by offering careful criticisms of the individual model and social model of disability, the thesis allows the two approaches to come under scrutiny, showing that the assumptions that are often taken for

granted within these models may be interacted with and understood in a variety of ways.

In using Bauman's four traits of sociological thought, the thesis will be able to offer a descriptive analysis of scholarly interest, whilst minimising the risk of normative claims or trivialising the complexity of the area of inquiry that is disability. Furthermore, by taking two networks of understandings and practices as its central characters, the thesis will defamiliarise the two approaches, thereby lending itself to further analysis in the future.

Structure of the Thesis

Chapter Two covers the medical approach, medical sociology, and the individual model of disability. The section *The Medical Approach* serves as a brief introduction into this approach, which is described as a collection of attitudes, assumptions, and practices that have been informed by medical understandings of disability. These understandings are characterised by an emphasis on the medical profession, which treats disability as a pathological state caused by biological and physiological dysfunctions. These medical understandings are then used to explain the experiences of disabled individuals, who are treated as victims that will inevitably be faced with suffering and dependence on others. This tendency to locate disability in the body means that disability is often treated as a personal problem that is confined to the individual.

The section *Medical Sociology* offers a description of a field that has been informed by the medical approach. This field studies human behaviour regarding medical knowledge and practices and the social forces that relate to them. Following this is the section *Levels of Analysis*, which shows how medical sociology analyses disability as a pathological, deviant state at the micro, middle-range, and macro level. This is not to argue that understandings of disability in medical sociology are limited to the medical approach; indeed, the field is comprised of various accounts that approach disability in different ways. However, due to the brevity of the thesis the analysis of this field will be limited to examples that are relevant to the medical approach.

The section *The Individual Model of Disability* offers a critical analysis of a model that is informed by the medical approach. The individual model reflects the medical approach in its tendency to treat disability as a personal problem, whilst emphasising the role of the medical profession. This is evident in the use of language and modes of measurement that focus on degrees of functional limitations and deficiencies. Following this is the section *Criticisms: Personal Tragedy and the Normal Body*, which describes some prominent criticisms that have been levelled against the individual model, specifically in regard to the role of the professional and the tendency to treat disabled individuals as victims.

Chapter Three describes the social approach to disability, disability studies, and the social model of disability. The chapter begins with the section *The Social*

Approach, which treats disability as a social matter that may be dealt with through social, rather than medical, attention. This is coupled with an emphasis on analysing how social forces may increase experiences of disability by failing to take into account the needs of disabled individuals.

The section *Disability studies/ Not Disability Studies* offers an example of a field that adopts the social approach in its analysis of disability and the social forces that relate to it. In this section the field is described as a multi-disciplinary field of critical analysis, that has been informed by the discipline of sociology, which offers a contrarian understanding of disability. This is supported by discussion clarifying what is and is not meant by the title disability studies. This is not included to discredit other fields and approaches that may study disability, but rather deals with the point that disability studies is considered by its contributors to be a distinct field, characterised by specific understandings and approaches.

This is followed by the section *Disability Studies and Critical Analysis*, which refers to a number of criticisms that disability studies has levelled against the medical approach. In so doing the thesis will describe the emphasis disability studies places on the rejection of disabling barriers and the social oppression of disabled individuals. This is done not as a means of advocating disability studies over the medical approach, but as a way of illustrating the fact that the field itself is built around a critical engagement with understandings of disability that are often taken for granted within other fields.

Finally, the section *The Social Model of Disability* is a critical analysis of a model that is intimately related to the social approach and disability studies, thereby bringing home the discussion of the social approach. The social model uses language that distinguishes between “impairment”, which is confined to physiological, sensory, or intellectual dysfunctions, and “disability”, which refers to the social limitations that are placed on top of ones impairment. The chapter ends with the section *Criticisms: Impairment*, which describes a number of issues regarding the social model’s more general use of language and the implications that this may have for impaired individuals.

CHAPTER 2 – The Medical approach

The Medical Approach

The medical approach treats disability as a personal problem confined to the body of the individual. This understanding springs from a belief in medical knowledge as being the most legitimate means of understanding and treating the body. Within this knowledge-base the body is objectified as an area of study and divided into separate systems, which are positioned as the site of disability (Van Krieken 2000, 350). Hence, in the medical approach disability is explained as being caused by biological and physiological dysfunctions.

This explanation is supported by an emphasis on the role of medical professionals, with medical and health-care experts such as doctors, psychologists, physiotherapists and occupational therapists holding dominant positions of authority in this context, followed closely by professional nurses and support workers (French and Swain 2001). These professionals serve to diagnose disability, as well as prescribe the subsequent needs and appropriate modes of treatment and care for disabled individuals (Barnes *et al.* 1999, 21). This has led to the medicalisation of disability, with disability being understood as a pathological state needing medical attention (Linton 1998, 527).

This pathological state is seen as the cause of whatever social limitations may face disabled individuals, with their physiological and biological dysfunctions being linked to certain hardships that they must learn to deal with and, if possible,

minimise or overcome (Swain *et al.* 1993). This leads to disabled individuals being viewed as "victims" that are often pitied by other members of society (Barnes *et al.* 1999, 6)[2]. Within disability studies and the social model, this emphasis on disability being an undesirable personal problem has been referred to as the "personal tragedy" approach (Oliver 1990), which is discussed in more detail in Chapter Three.

Such an emphasis within the medical approach on the hardships of disability lends itself to the cultural assumption that disability inevitably leads to dependency (Thomas 2007, 96). Disabled individuals are seen as having needs that they are unable to attend to alone and as requiring the care and support of others, if they are to achieve and maintain a healthy standard of living. This point of view is a reflection of the emphasis put on the medical professional, whose knowledge of the disabled body often takes precedence over the experiences of disabled individuals as an authority on disability.

By positioning disabled individuals as being in need of professional care in this way, the medical approach tends toward what Trickett *et al.* (1994, 18) refer to as "person-fixing rather than context changing". Disabled individuals are positioned as objects of professional attention, being acted on by a variety of experts, rather than being active themselves (Swain *et al.* 1993, 26). This limits disabled individuals' capacity to interact with the terms of their disablement, instead being

[2] For an excellent discussion on the "the prototype effect" and its relationship to conceptions of disability see chapter three of Carlson (2010).

informed of their circumstances by experts who then define their needs and the manner in which these needs are to be met (Barnes *et al.* 1999, 21).

Another important characteristic of the medical approach is that, in defining disability, the disabled body is often compared to the able-body (Linton 1998, 532). This imagines an ideal level of biological and physiological functioning that is considered necessary for a body to be considered "normal"; if the body does not meet these levels of functionality then it is to be considered dysfunctional and "abnormal". If an individual's body is recognised as being dysfunctional and "abnormal" they may be labelled as being disabled by the medical profession, which in turn serves to explain their perceived abnormality. Through this process a direct distinction may be made in the medical approach between being "disabled" or "not disabled" (Kutner 2007, 101).

To be disabled is to be part of a minority group characterised by a deviation from the biological or physiological norm. Once a part of this minority group, such attributes as dependence, neediness and suffering are associated with the individual (Barnes 1996; Finkelstein 1980; Oliver 1990). This is at odds with the value placed on self-sufficiency and independence within contemporary society, thereby resulting in disabled individuals having a devalued social status (Thomas 2007, 88). As a result, disability is treated as a form of social deviance, with disabled individuals being marked out as "different" (Thomas 2007, 49). Thus the tendency within the medical approach to treat disability as a deviation from the biological norm influences the manner in which disability is analysed within other

fields, often being viewed through what Thomas (2007, 4) refers to as a "social deviance lens".

Through this lens disabled individuals become objects of theoretical discussion and empirical inquiry (Linton 1998, 526). Empirical studies take precedence over the personal experiences of disabled individuals as the emphasis is placed on studying disability as a biological, physiological problem that must be dealt with (Turner 1995, 6). In other words, disability is treated as an issue occurring in the body that has real implications for the disabled individual and the world around them. Disability thus becomes an area of knowledge characterised by a deviant bodily state and the social forces that relate to it (Thomas 2007, 4).

This tendency to treat disability as a pathological state confined to the body is but one way in which disability may be understood. Indeed, as Chapter Three will show, the social approach offers a contrarian account that approaches disability as a social phenomenon to be interacted with and influenced in a variety of ways. For now, a section on medical sociology will show how this field tends to view disability primarily as a form of social deviance caused by biological and physiological dysfunctions. This will be supported by a discussion of how this tendency is evident at the micro, middle-range, and macro levels of analysis that are used within this field.

Medical Sociology

Medical sociology is a field within the discipline of sociology which attempts, not always successfully, to weave a path between human biology, physiology and sociological phenomena (Turner 1995, 6). If sociology is defined as "the scientific study of human behaviour in groups and of the social forces that influence that behaviour" (Doob 1991, 4), then medical sociology can be regarded as the sociological field of study concerned with human behaviour regarding medical knowledge and practices and the social forces that relate to them (Matcha 2000, 6).

The underlying theme of medical sociology is that medicine and social forces are intimately connected. Thus, in order to understand the role of medical knowledge and the medical profession within society, certain social factors must be considered. Furthermore, in order to understand certain social phenomena it is important to understand the ways in which medical knowledge permeates social life (Illich 1999). In this way, medical sociology reflects Foucault's (1980, 151) comment that sociology and medicine are inextricably linked; that modern medicine may be considered to be applied sociology and sociology applied medicine (Turner 1995, 6). While this conception of medical sociology may serve as a starting point, the theoretical issues and divisions that occur within this field make finding a single definition or methodological description a difficult task (Petersdorf and Feinstein 1981).

In an expanded definition, Ruderman (1981, 927) argues that: “medical sociology is the study of health care as it is institutionalized in a society [sic], and of health, or illness, and its relationship to social factors”. This definition draws a direct relationship between health and social forces, with the term “institutionalized” suggesting that health-care, rather than simply being a component of medical knowledge, involves a variety of groups with specific norms and values in relation to the matter of public health (Matcha 2000, 6). It also illustrates the correlation between medical sociology and health and illness, which in turn is related to various topics, including (but not limited to) the experience and lay perceptions of disability and social conceptions of the body (Nettleton 1995, 8).

In an extensive description, Weiss and Lonnquist (1997, 1) argue that:

> Medical sociology is the subfield which applies the perspectives, conceptualizations, theories, and methodologies of sociology to phenomena having to do with human health and disease. As a specialization, medical sociology encompasses a body of knowledge that places health and disease in a social, cultural, and behavioural context.

In this description, medical sociology is grounded in the analysis of human behaviour relating to health and illness, the medical profession and its associated services, and the body (Matcha 2000, 6). By treating medical sociology as a specialisation within sociology, this description also suggests a more specific focus within the field, thereby distinguishing itself from Ruderman’s (1981, 927) more open ended definition.

In line with these descriptions of it being a specialised field concerned with medical knowledge and practices, medical sociologists often discuss disability specifically in relation to medical understandings of the body. These understandings treat disability as a pathological state caused by biological or physiological dysfunctions that are confined to the body of the individual (Cockerham 1998, 146). As a result, medical sociology often positions disability alongside illness and disease as a deviation from the normal, healthy body (Barnes *et al*. 1999, 21). In this way, medical sociology is informed by many of the themes and assumptions of the medical approach, including the tendency to view disability through a "social deviance lens" (Linton 1998, 533; Thomas 2007, 4).

By viewing disability through this social deviance lens, medical sociologists formulate disability in a particular way that influences the manner in which it is analysed as an area of inquiry (Linton 1998, 532). This is evident in the levels of analysis that are used within medical sociology, which refer to micro, middle-range, and macro sociological theories in order to describe the relationship between disabled individuals and medical knowledge and practices, their associated institutions, and other social forces (Barnes *et al.* 1999, 34; Turner 1995, 4; Layder 1997). In discussing these levels of analysis, a number of sociological theories will be referred to, with an emphasis on those that exemplify this tendency to describe disability as a social problem.

Levels of Analysis

The first level, analysis at the micro level, describes how disability and the medical profession are experienced from the perspective of the individual. This approach considers the feelings of the individual, particularly in regard to the influence of self-identity and routines in their day-to-day interactions with medical knowledge and practices (Barnes *et al*. 1999, 34). Sociological theories that exemplify this level of analysis within medical sociology include symbolic interactionism, which emphasises the role of communication and labels, and ethnomethodology, whereby the objectification of the body is traced to underlying assumptions about health and illness (Barnes *et al*. 1999, 34).

Symbolic interactionism was influential within medical sociology in the United Kingdom in the 1970s and 1980s, with a range of empirical studies examining doctor-patient interactions and the role of the medical professional being published (Atkinson 1981; Hughes 1977; Silverman 1981; Strong 1979; Webb and Stimson 1976). These studies focused on the effect of disability on friends and family (Bury 1982; Radley 1989), and the ways in which groups of disabled individuals collaborated and shared their experiences to make sense of their circumstances (Kelleher 1988; Scambler 1989).

In an example of how symbolic interactionism and micro level analysis are relevant to discussions of disability within medical sociology, Scott (1969, 14) discusses how people with visual impairments become “blind”:

> The disability of blindness is a learned social role. The various attitudes and patterns of behaviour that characterize people who are blind are not inherent in their condition but, rather, are acquired through ordinary processes of social learning. Thus, there is nothing inherent in the condition of blindness that requires a person to be docile, dependent, melancholy, or helpless … Blind men are made, and by the same processes of socialization that have made us all.

Scott argues that the blind are subject to a socialisation process, "the purpose of which is to prepare a disabled person to play a type of deviant role" and "make blind persons out of people who cannot see" (Scott 1969, 16). This example fits with the description of sociology as "the scientific study of human behaviour in groups and of the social forces that influence that behaviour" (Doob 1991, 4) and demonstrates the manner in which disabled individuals may learn to live with their deviant role.

Another sociological tradition that uses this level of analysis within medical sociology is ethnomethodology. Ethnomethodology focuses on studying, documenting, and interpreting how individuals construct and employ the meanings that are often taken for granted in daily life and routines (Thomas 2007, 27). Sociologists using this approach often interrogate these meanings, looking at how underlying understandings and expectations may influence social interactions. For example, it is often taken for granted that disability constitutes a form of social deviancy that should be either treated or avoided whenever possible (Thomas 2007, 28). These understandings reflect medical conceptions of what constitutes the "normal body", the standards attached to such conceptions,

and the expectations placed upon those who do not meet these standards (Barnes *et al*. 1999, 21; Rapley 2004, 46-7).

One effect of these taken for granted medical understandings and standards is that disability is often associated with a diminished level of competence (Thomas 2007, 28). This diminished competence means that disabled individuals membership in society is compromised, leading to a devalued social status. Disabled individuals are thus subjected to "degradation ceremonies", in which they are rendered victims by social meanings that diminish their moral authority and position them as incompetent disrupters of social order (Garfinkel 1956). In order to avoid these degradation ceremonies disabled individuals must engage in normalisation efforts, whereby they rely on the support of other, competent members of society such as the medical professional (Thomas 2007, 28).

The second level of analysis may be described as a "middle-range theory", attempting to bridge the gap between micro level and macro level accounts within medical sociology (Barnes *et al.* 1999, 36). This level focuses on the construction and use of disease categories, under which individuals are classified and regulated by medical professionals and organisations (Turner 1995, 4). These categories, which may include such labels as "ill" and "disabled", are of interest in medical sociology owing to the fact that they are intimately related to social roles and norms, giving insight into how certain social groups and institutions make sense, of and respond to, deviations concerning health and the body. Thus, it may be argued that this

level of analysis is tied to discussions of social control and cultural practices (Barnes *et al*. 1999, 34).

Susser and Watson's (1971) description of disease, illness, and sickness serves as an example of how medical sociologists may interrogate medical categories. According to this description disease, illness, and sickness occur in a particular order, with biological or physiological dysfunctions causing a social response. Disease is a concept which describes these dysfunctions; illness refers to the individual's subjective awareness of these dysfunctions; and sickness refers to the designation of social roles in response to these first two categories. Among the most influential sociological theories relating to this distinction between the biological and the social aspects of health is the notion of "the sick role" (Parsons 1951; 1975).

This notion distinguishes between the biological bases for illness (or disease, as Susser and Watson refer to it above) and the social bases for illness, with sickness being both a biologically and a socially altered state (Nettleton 1995, 70). This altered state constitutes a special kind of deviant behaviour, in which the individual fails to "fulfil the institutionally defined expectations of one or more of the roles in which the individual is implicated in society" (Turner 1999, 101). However, because individuals are often not to blame for their sickness (owing to its biological basis), they are granted certain rights, privileges, and obligations (Nettleton 1995, 70). It is these privileges and obligations that characterise "the sick role" (Parsons 1975).

Individuals adopting the sick role are not expected to uphold their normal social obligations such as work, study, domestic work, etc. However, they are expected to seek out and cooperate with medical aid in order to get well. This emphasis on recovery and the role of the professional are crucial to what Freidson (1970) refers to as the "conditional legitimacy" of the sick role. Individuals who do not fulfil this condition are thus regarded as illegitimate, with their access to the rights and privileges of the sick role being restricted and stigmatised by others (Nettleton 1995, 71). This description is particularly relevant to disabled individuals, who are expected to accept their diagnosis as being disabled, as well as the authority of the medical professional in dealing with their disability (Barnes *et al*. 1999, 21).

The third level of analysis within medical sociology is the macro analysis of societal organisations regarding health-care, the state, and the economy (Turner 1995, 5). This level is used in functionalist sociology, which envisions medical practices as involving a consensual web of relations (Thomas 2007, 17). It is also drawn on in a number of conflict theory approaches, which deal with issues of power and conflict, as expressed through matters such as social disadvantage, discrimination, and privilege linked to health and illness (McKinlay 1984). As the sick role has already served as an example of a functionalist account within medical sociology, the examples of this macro level of analysis will be restricted to conflict theory.

Conflict theory argues that society is made up of different competing social groups, each with its own interests, with a dominant group often influencing the activities and behaviour of other groups (Barnes *et al*. 1999, 35). Dominant groups (medical professionals, health-care workers, government organisations, etc.) influence others through what is referred to as "ideology", a process through which the interests of the dominant group are presented as universal, using such means as education and the media (Althusser 1984; Giddens 1979). In medical sociology this argument is made primarily in relation to health inequalities, with many sociologists adopting a Marxist political economy approach to analysing health-care systems (Barnes *et al*. 1999, 35; Matcha 2000, 15-17).

This perspective has been particularly popular in the United States, where the US health-care system is seen as a powerful capitalist business, driven mainly by the pursuit of profit (Ehrenreich and Ehrenreich 1970; Navarro 1976; Waitzkin 1983). Within this capitalist system, it is in the interest of the dominant groups to keep the population healthy, thereby supporting the healthy functioning of the market. Disability is portrayed as a deviation from the norm located in the body, that limits one's ability to contribute to the market. This representation is exacerbated by the fact that disabled individuals sometimes require the support of others to maintain economic security. As this is at odds with the value that is placed on independence within the capitalist system, disabled individuals often have a lowered social status.

A number of critical medical sociologists have argued that this process reflects the individualism of capitalist society, which often obscures wider social issues by placing the blame on individuals (Ehrenreich and Ehrenreich 1970; Navarro 1976). This individualism tends to place importance on medical services that focus on curing the individual (thereby reaffirming the privileged position of the medical professional), rather than preventing illness through policy and broad social change (Turner 1995, 168). Furthermore, this emphasis ignores arguments suggesting that the capitalist economic system is often a contributor to disability, since such things as social inequality and poverty contribute to the experience of disability (Thomas 2007, 30). This final point will be explored in more detail in the discussion on the social approach and disability studies.

Within each of these levels of analysis disability is viewed as a pathological, deviant state, located in the body, a state having real social effects. This is evident in micro level studies that explore how individuals learn to be disabled and come to terms with their deviant social role (Bury 1982; Radley 1989, Scott 1969); middle-range theories such as that of the sick role, which describe disability as an undesirable condition whereby biological and physiological dysfunctions restrict the individual from participating in “normal” social responsibilities and activities (Nettleton 1995, 70; Parsons 1975); and macro level descriptions of society, in which having a disability means having a lowered social status due to a decreased ability to contribute to the capitalist system (McKinlay 1984).

This is not to say that these levels of analysis are confined to the medical approach. Indeed, the micro level studies discussed often analyse how the disability role is negotiated between the patient and the medical professional, while the political economy approach is critical of the ways in which the medical profession is driven by a pursuit of profit. Nevertheless, it remains the case that the medical approach's tendency to treat disability as a personal problem confined to the body of the individual has been influential within the field of medical sociology, informing the manner in which disability is understood and approached as an area of inquiry.

The Individual Model of Disability

The individual model of disability treats disability as being an individual problem, hence the title "individual model" (Barnes *et al*. 1999, 21). It focuses on "bodily abnormalities" in its understandings of disability, measuring the extent of an individual's disability by the degree of their functional limitations or deficiencies. These degrees of disability all contribute to the wider classification of the individual as an "invalid" (Barnes *et al*. 1999, 21). Thus, the individual model tends to see disability as a personal problem, with bodily abnormalities being the cause of whatever limitations, deficiencies or incapacities disabled individuals may experience.

In the individual model the severity of a disability is measured in relation to particular levels of incapacities. These levels are seen as being directly related to the needs of disabled individuals and their appropriate treatments (Barnes *et al*.

1999, 21). In order to measure the disabled body and the capabilities of disabled individuals in this way the individual model uses definitions that separate disability into three areas, referred to as the International Classification of Impairments, Disabilities and Handicaps (ICIDH).

Impairment is defined by the World Health Organisation (WHO) as "Any loss or abnormality of psychological, physiological or anatomical structure or function" (WHO 1976, 27). This definition describes impairment as being a medical issue that is confined to the body. It positions impairment as a condition in which parts of the body do not work properly, resulting in specific things that the disabled individual can not do (Barnes *et al*. 1999, 23).

Disability is seen as the direct result of impairment, being described as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (WHO 1976, 28). While missing a leg would be classed as an impairment, the disability resulting from such an impairment would be limited mobility, in comparison to what is considered "normal". This description serves as the link between impairment and the language of incapacities, deficiencies and the "invalid" referred to earlier.

Handicap extends these restrictions to a "disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of

a role (depending on age, sex, social and cultural factors) for that individual" (WHO 1976, 29). For example, owing to the limited mobility caused by their impairment, disabled individuals may be unable to obtain a driving licence and are thus handicapped in their capacity to drive to work each day, which may further limit their ability to find and maintain certain jobs. While this term extends these understandings to the social consequences of impairment, it still treats these issues as being confined to the personal circumstances of the individual, as diagnosed by the medical profession.

These three areas are treated as occurring in a particular order, with impairment being positioned as the cause of disability and disability being the cause of handicap. It is worth noting here that within these three areas the environment in which these disadvantages occur is represented as neutral with no significant need for interrogation (Barnes *et al*. 1999. 25). Hence, the three areas found within this particular act of categorising all maintain the individual as the site of disability and as such subscribe to the tendency to see disability as a personal issue. This is done through the use of medical understandings of the body, which are then used to diagnose the cause of whatever social limitations disabled individuals may encounter. As such, the solutions suggested by the individual model to the problem of disability concentrate on medical intervention and rehabilitation.

Criticisms: Personal Tragedy and the Normal Body

As the previous sections have shown, the medical profession provides the dominant knowledge-base within the medical approach to disability and remains

so within the individual model. As a result, the medical profession has been a particularly influential force in creating and restricting conceptions of disability within this model (Cocks *et al*. 1996, 206). This is evident in the levels of incapacities referred to above, which each treat disability as a personal problem, thereby adhering to the individualism of the medical approach.

Hence, within the individual model, disability becomes the domain of the expert, representing a pathological state that requires specialised knowledge and professional analysis. Disabled individuals are treated as objects of professional attention, with medical professionals holding exclusive jurisdiction over the disabled object (Barnes *et al*. 1999, 21). This is confirmed by the importance that is placed on treatment and intervention, in which the opinions of medical professionals and support workers often taking precedence over the personal experiences of disabled individuals.

The dominance of the medical profession over the disabled body means that whatever solutions may be offered to the disabled individual must first correspond with the views of certain professionals. This puts disabled individuals in a dependent position, having to rely on professionals to diagnose their disability before therapeutic and social support may be provided. The result is that disabled individuals are restricted from interacting with the terms of their disability while becoming increasingly dependent on medical professionals. In this way, the individual model emphasises the role of medical professionals in defining the

personal circumstances and corresponding needs of disabled individuals (Barnes *et al*. 1999, 26).

It is this emphasis on disability being a personal problem in need of professional attention that has led to the argument that the individual model subscribes to what has been referred to as a "personal tragedy" approach (Oliver 1990). This approach focuses on bodily "abnormalities", disorders, and deficiencies, positioning disabled individuals as "victims" of "tragic" circumstances (Barnes *et al*. 1999, 21). These "victims" are then set apart from ordinary, able-bodied individuals and portrayed as being "unfortunate, useless, different, oppressed and sick" (Hunt 1966, 146).

This portrayal is then used as a means by which to explain the experiences of disabled individuals, thereby contributing to the stereotypes and cultural assumptions associated with the medical approach. In particular, the personal tragedy approach supports the assumption that disability inevitably leads to dependency (Thomas 2007, 96). That is, disabled individuals are positioned as victims who, because of their own circumstances, are incapable of accomplishing certain tasks without the support of others (Barnes *et al*. 1999, 10). As a result, disabled individuals require constant assistance and professional care in order to better cope with "their disability" (Swain *et al*. 1993).

While the notion of the personal tragedy approach has been a popular criticism of the individual model, it has not been beyond criticism within the disability studies literature. For example, Carlson (2010, 7) points out that it cannot be assumed that the personal tragedy approach occurs in the same manner for all impaired individuals:

> [T]he notions of tragedy and suffering often assume a different hue relative to persons with severe intellectual disabilities. For example, in some cases the primary emphasis on suffering *beyond* the severely disabled individual – experienced by family members and society at large, and *not* by the person with the disability – suggests that the personal tragedy model cannot be assumed to function in identical ways for all persons with disabilities.

This recognition of the fact that the experience of disability varies between disabled individuals contributes to an argument that is central to the social model, and will be discussed further in Chapter Three.

Another critical response questions the use of the term "normal" in the individual model's understanding of disability. In its definition of impairment the individual model uses medical conceptions of what is considered to be the "normal" body, against which the impaired body is then compared. This is then extended to explaining the limitations that may occur as a result of this impairment and the social consequences that these limitations may cause (Rapley 2004, 46-7).

Criticisms of this method question the boundary lines that differentiate between "normal" and "disabled". For example, Barnes *et al*. (1999, 25) ask at what point

does blood pressure, or body weight or shape, change from being considered "normal" to being considered "pathological". In another example they argue that, while an individual may wear glasses in order to assist with a visual impairment, glasses have become so normalised that such individuals may not be considered to be disabled (Barnes *et al*. 1999, 25).

These criticisms have led to the individual model revising its definitions of impairment, disability and handicap, resulting in what has been referred to as the ICIDH-2 (Barnes *et al*. 1999, 27). This new mode of classification uses a "biopsychosocial" model that attempts to connect the medical conceptions of impairment with the social consequences of disability (Barnes *et al*. 1999, 27). It uses the categories of "impairment", "activity limitations" and "participation restrictions" in order to establish a framework which identifies and distinguishes between areas of impairment that are the subject of medical attention and intervention and areas where the social environment may be regarded as a contributor to the experience of disablement (Barnes *et al*. 1999, 27). It should be noted however, that this new mode of classification treats such social limitations and restrictions as being the consequence of the individual's impairment, thereby maintaining the individual model's tendency to treat disability as a personal problem.

To summarise the individual model, the modes of measuring the levels of incapacities discussed earlier treat impairment as being a personal issue that is confined to the individual. This impairment is designated by comparing the

impaired body to medical conceptions of the “normal” body. This is then extended to explanations of disability and handicap, which were later revised as “activity limitations” and “participation restrictions”. The model has been criticised for using what has been described as a “personal tragedy” approach, which positions the impaired individual as a victim who is dependent on others for assistance, with medical professionals being at the forefront of rehabilitative support efforts. This all contributes to impairment and disablement being considered an undesirable and abnormal condition: “Hence the assumption is, in health terms, that disability is a pathology, [sic] and in welfare terms, that disability is a social problem” (Oliver 1996, 30).

Conclusion

This chapter has described the ways in which the medical approach to disability understands disability as personal problem that is confined to the individual. This is informed by an emphasis on the medical profession, which individualises disability as a pathological state caused by biological and physiological dysfunctions. Disabled individuals are represented as being dependent on others for care and support, requiring assistance in order to maintain a healthy standard of living. Such attitudes and tendencies often result in disabled individuals having a limited ability to interact with the terms of their disability, with medical knowledge and professional authority often taking precedence over individual experiences.

As a result of these understandings, disability is often viewed through a "social deviance lens", with disabled individuals being seen as "different" (Thomas 2007, 4). This tendency to treat disability as a form of social deviance is exemplified in medical sociology. Medical sociology uses sociological perspectives that see biology, physiology, and social phenomena as being intimately connected. Hence, within this field disability is treated as being a biological and physiological state that has particular social implications. In order to demonstrate this, the chapter described the levels of analysis that are used within this field, showing how disability may be examined in regard to its connection to disabled individuals on the micro level, the medical profession and other health-care systems, as well as the influence of social forces on the macro level.

Finally, the chapter offered an analysis of the individual model of disability. This model is informed by the medical approach in its tendency to locate disability in the body, with "impairment", "disability", and "handicap" all being caused by the individuals own biological or physiological dysfunctions. This was followed by a section describing a number of criticisms that have been levelled against the individual model, with an emphasis on the manner in which the model positions disabled individuals as victims whilst comparing them to other "normal" bodies.

CHAPTER 3 – The Social Approach

The Social Approach

The social approach treats disability as a social issue that is directly influenced by social forces. These social forces are considered to be a key contributor to the "problem" of disability, in that they often fail to accommodate the needs of disabled individuals (Hevey 1993; Oliver 1990; Swain *et al*. 2003). The social approach therefore moves the focus away from the body and towards social relations, public attitudes, environments, and the impact that they may have on disability. Hence, in the social approach disability is explained as a social matter that may be dealt with through social, rather than medical, attention.

The social forces under consideration include a wide variety of different factors that are not limited to immediate social interactions. For example, the environment may play an important role in that certain buildings may be accessible only by stairs, thereby contributing to experiences of disability for individuals who use wheel-chairs. Another example may be how certain economic factors contribute to the financial difficulties faced by disabled individuals, leading them to rely on the financial support of others (Barnes *et al*. 1999, 123). Thus, the term "social forces" may be considered to refer to a wide range of different factors occurring on the micro to macro level.

In an example of how social forces contribute to the experience of disability, Barnes *et al*. (1990, 13) make the following argument in regard to employment:

> [T]he failure of a disabled individual to find paid employment might be explained in terms of personal shortcomings. However, if the overall rate of unemployment for disabled people is much higher than that recorded for the rest of the population, this suggests structural discrimination in the sphere of employment against disabled people generally, as well as possible connections with other disabling barriers. What had been regarded as an individual inadequacy is perhaps more plausibly explained as a collective social disadvantage.

According to this argument there are oppressive structural features in society that contribute to the collective social disadvantage of disabled individuals. These structural features are characterised by social restrictions "ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to excluding work relations and so on" (Oliver 1996, 33). This is what is meant by "disabling barriers".

By drawing attention to these disabling barriers and the social forces that contribute to them, the social approach shows that at least some elements of disability are external to the individual. As a result, the biological or physiological dysfunctions that characterise a disability are no longer considered to be a sufficient means of explaining the experiences of disabled individuals. Rather, disability is viewed on a spectrum intimately related to social and environmental forces, which influence the extent to which disability is experienced by disabled individuals (Barnes *et al*. 1999, 123).

In viewing disability as occurring on a spectrum in this manner, the social approach allows disabled individuals more room to interact with the terms of their disability. For example, the social approach may be referred to in order to reject the assumption that disability inevitably leads to suffering and dependence, arguing instead that social forces exacerbate such characteristics (Oliver 1996, 33). An implication of this is that, rather than being "victims" of their biological or physiological circumstances, disabled individuals become "victims" when interacting with certain social forces.

This is significant because it has enabled disabled individuals to resist certain attitudes and assumptions, whilst directly and critically interacting with the terms of their disability, as Swain *et al*. (2003, 24) argue in reference to the social model:

> The importance of the social model of disability is that, as a model providing an alternative understanding of the experience and reality of disability, it has given disabled people a basis on which to organise themselves collectively. Using the social model as a basis for explanation, disabled people have been drawing attention to the real problems of disability: the barriers they face; the patronizing attitude they have to deal with; the low expectations that are invested in them; and the limits available to them.

Thus, in the social approach the experiences of disabled individuals serve as the basis for analysis, rather than their biological or physiological characteristics (Shakespeare 1998, 251-4).

This has important implications for the role of the medical profession, which is treated as one among many of the social forces that interact with disability. Rather than treating medical professionals as the central authority on disability, the social approach draws attention to the different ways in which they may positively or negatively influence the experiences of disabled individuals. For example, the tendency to treat disability as a pathological state confined to the individual diminishes disabled individuals' ability to interact with the terms of their disability, thereby adding further to their experiences of being disabled (Linton 1998, 527). As the following sections will show, this critical analysis of the medical profession has been central to disability studies.

Disability Studies/ Not Disability Studies

Disability studies is a field comprised of a wide variety of social movements, organisations, and literature concerned with the many different aspects that comprise "disability" (Barnes *et al.* 1999, 1). These aspects include such areas as disability policy and politics, the role of medical institutions and medical professionals, and the ways in which society produces, restricts, and relates to conceptions of disability (Barnes *et al.* 1999; Oliver 1990; Swain *et al.* 2003). In analysing these areas, contributors to disability studies are particularly interested in the position of disabled individuals and how experiences of disability are influenced by social forces (Finkelstein 1980; Hughes 1999).

Unlike medical sociology, disability studies is not considered to be a field occurring within the discipline of sociology, but rather draws upon a variety of disciplines such as sociology, history, psychology, and political science. This is reflected in the variety of works that comprise the field, with contributors ranging from social and political organisations such as the Union of the Physically Impaired Against Segregation (UPIAS) and The Disability Alliance (TDA); to sociological accounts incorporating interactionism (Tregaskis 2004) and critical theory (Bowe 1978; Swain *et al.* 2003); to philosophical reflections in ethics and phenomenology (Carlson 2010; Hughes and Paterson 1997). Thus, disability studies may be described as a multi-disciplinary field concerned with "a socio-political-cultural examination of disability" (Linton 1998, 525).

Although disability studies is a multi-disciplinary field, the emphasis that sociology places on "the study of human behaviour and the social forces that influence that behaviour" has been particularly influential in the development of its arguments (Doob 1991, 4). Indeed, contributors to disability studies often draw on varying degrees of sociological insights in order to critically analyse conventional thinking and practices relating to disability (Barnes *et al*. 1999, 2-3). This is supported by Thomas (2007, 7), who argues that:

> The majority of writers within disability studies consider sociology – understood broadly to include much that travels under the titles 'social policy', 'gender studies' and 'cultural studies' – to be the social science that offers theoretical and methodological resources of greatest relevance.

Thus, although it is not considered a field in sociology, it remains that the field of disability studies has been highly influenced by sociology.

While disability studies may be referred to as a distinct field that critically analyses disability, the title “disability studies” is also used within organisations that adhere to the understandings of the medical approach. This is evident in the fact that the title is often used by health-care workers, occupational therapists and universities to refer to the study of disability in general (Linton 1998, 526). This practice often restricts disabled individuals’ ability to contribute to such fields and interact with the terms of their disability, thereby perpetuating the discriminatory social structures that oppress disabled individuals (Abberley 1987; Barnes 1996; Hughes 1999). As a result, the general use of this title runs the risk of compromising the integrity of disability studies as a field of critical analysis that promotes the social approach to disability (Linton 1998, 518).

The distinction between what Linton (1998) refers to as “disability studies” and “not disability studies” is made in an attempt to discuss this issue. While the borders between these two areas are not fixed, there are distinctive differences between them, as the discussions included in the thesis thus far has illustrated. By distinguishing between what does and does not count as disability studies, the field is refined and further distinguished from other fields, whilst also implying a discrete understanding of what is meant by the title disability studies.

The title “disability studies” refers to a specific field of study that adopts the social approach in order to offer a critical socio-political-cultural analysis of disability. This new understanding emphasises how social forces and disabling barriers may increase or decrease experiences of disability, rather than treating disability as a problem that is confined to the individual. On the other hand, “not disability studies” refers to social practices or organisations that deal with disability whilst not adopting the social approach, such as the medical profession. (Linton 1998, 525-6).

For example, medical sociology studies disability in relation to social forces on the micro, middle-range, and macro level. However, rather than critically engaging with the different ways in which disability may be formulated and examined, medical sociology often takes its own understandings for granted, viewing disability through a social deviance lens as a social problem and then treating this attitude as “natural” (Barnes *et al*. 1999, 13). Hence, while these approaches within medical sociology may study disability, they do not do so in the context of the social approach and thus are “not disability studies”.

In contrast, the social model has been referred to as “the big idea” of the social approach and disability studies (Thomas 2007, 57), with many contributors to the field using this model as a basis for their own work and

discussions on disability (Hughes and Paterson 1997; Oliver 1996; Shakespeare and Watson 2002; Swain *et al*. 2003 Thomas 2007). This model shifts the emphasis away from the individualism evident in the medical approach and medical sociology, focussing instead on external social forces and the manner in which they may increase or reduce experiences of disability. Hence, the social model uses the social approach to formulate new understandings of disability that may not have developed within the restrictions of the medical approach and may thus be considered an integral part of disability studies (Thomas 2007, 49).

A central theme of disability studies is its challenge to the "medical approach" to dealing with disability. The medical approach is characterised by attitudes and tendencies that restrict disabled individuals' ability to interact with the terms of their disability (Barnes *et al.* 1999, 2). This has led to the tenet within disability studies that disabled individuals form a socially oppressed and excluded group (Barnes 1996; Finklestein 1980; Oliver 1990; Swain *et al.* 2003). It is this idea that forms the basis of disability studies, with the field building on a critical analysis of the medical approach. Hence the following section will analyse disability studies most prominent criticisms of the medical approach in order to better situate it as a field of critical analysis informed by the social approach.

Disability Studies and Critical Analysis

Disability studies is built around the argument that disabled individuals are systematically disadvantaged, marginalised, and excluded from society (Thomas

2007, 49). This argument accuses the medical approach of contributing to the social oppression of disabled individuals whilst restricting their ability to interact with the terms of their disability (Barnes 1996; Finklestein 1980; Oliver 1990; Swain *et al.* 2003). In opposition to this social oppression disability studies adopts a critical analysis of the language, assumptions, and tendencies that make up the medical approach. This section offers an overview of this critical analysis, detailing the arguments that characterise disability studies and the implications that they may have for disabled individuals, the medical profession, and medical sociology.

In describing social oppression, Young (1990, 41) argues that:

> In [an] extended structural sense oppression refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms – in short, the normal processes of everyday life. We cannot eliminate this structural oppression by getting rid of the rulers or making some new laws, because oppressions are systematically reproduced in major economic, political, and cultural institutions.

The assumptions and reactions of the public, institutions such as the medical profession and social hierarchies that position disabled individuals as a minority group all contribute to the oppression of disabled individuals. However, as Young argues, this is not the result of a deliberate attempt to oppress disabled individuals, but rather a result of current structural features that are taken for

granted within society (Young 1990, 41). It is these oppressive structural features and their corresponding assumptions that disability studies critically interrogates, condemning and opposing "disablism" in all its forms (Thomas 2007, 49).

The term "disablism" was introduced by Abberley (1987) in order to refer to social beliefs and practices that exclude, oppress, or otherwise disadvantage individuals because of their disability. Disablism functions in a similar manner to sexism, racism, ageism, and homophobia in society in that it isolates a group as a social minority on the basis of particular characteristics and social stereotypes, often resulting in discrimination and oppression (Barnes 1991; Thomas 2007, 4). This relationship between disablism and other forms of social oppression is described by Hunt (1966, 152-3), who argues that:

> Disabled people often meet prejudice, which expresses itself in discrimination and even *oppression*. … Maybe it is invidious to compare our situation with that of racial minorities in any way. The injustice and brutality suffered by so many because of racial tensions makes our troubles as disabled people look very small. But I think there is a connection somewhere, since all prejudice springs from the same roots.

In rejecting this disablism, disability studies begins by challenging the language that is used to discuss and describe disability within the medical approach. This is due to the recognition that understandings of social issues are intimately related to the language that is used in discussing them (Barnes *et al*. 1999, 6). So long as disability is defined in terms that connect it to a pathological, deviant state,

disabled individuals will continue to be subject to oppressive attitudes and assumptions that position them as victims.

This emphasis on language is coupled with a critical analysis of the manner in which certain discourses may produce, reproduce, or challenge the social oppression of disabled individuals. Discussions relating to disability are characterised by specific discursive practices, which themselves are contingent on various social and theoretical assumptions (Cocks *et al*. 1996, 287). In the medical approach these discursive practices are often taken for granted as representing "natural", unchanging attitudes regarding the "real object" of disability (Barnes *et al*. 1999, 13; Weeks 1982, 111). Disability studies rejects this tendency, arguing that such discourses are not true through the virtue of describing a "real object", but rather gain their truth effect from "the social practices that actually form the object about which the discourse speaks" (Weeks 1982, 111).

For example, a central component of the medical approach is the manner in which disability is presented as a pathological state resulting from bodily abnormalities that cause the disabled individual to be faced with certain difficulties (Barnes *et al*. 1999, 21). As this pathological state is presented as a medical issue it then follows that the most appropriate means of treatment is through the application of medical knowledge. Disability thus becomes an object of study within the medical profession, with the medical professional being positioned as an authority figure on the "problem" of disability (Linton 1998, 525).

As a result of this social practice of treating disability as a problem belonging to the domain of the medical profession, disabled individuals are positioned as being in need of medical assistance and professional supervision. Hence, the disabled object is formulated as a "pathological" state, in which the disabled "victim" depends on assistance to deal with this problem (Becker 1963; Finkelstein 1980; Oliver 1990). This supports the dominance of the medical professional and perpetuates the cultural assumption that disability inevitably leads to dependency (Thomas 2007, 96). These social practices then become a "natural" attitude, being taken for granted within the medical approach as referring to the "true" nature of disability, which in turn is used to explain the experiences of disabled individuals.

Disability studies challenges this tendency to take such discourses and practices for granted as "natural" by critically analysing and engaging with the underlying assumptions that inform them. For example, the medical practice of representing disability as a pathological state that requires the attention of medical professionals has been accused of perpetuating disablism by individualising disability (Oliver 1990). Within this discourse disability is understood as a personal problem that is confined to the biological and physiological characteristics of the individual, which in turn is used to explain the systematic inequalities that exist between disabled and non-disabled individuals (Barnes *et al*. 1999, 123). Thus, this understanding supports the assumption that the difficulties faced by disabled individuals are a result of their "natural" inferiority (Linton 1998, 523).

In response to this assumption, contributors to disability studies point out that it is always “the dominant group that defines itself as normative” (Thomas 1990, 239). As such, it may be argued that the tendency within the medical profession to treat disability as a personal problem reflects the power differences that exist between disabled and non-disabled individuals. This argument is supported by the fact that disabled individuals are measured against the ideal standard of physical, psychological, and sensory functioning set by the dominant able-bodied, non-disabled group (Linton 1998, 532).

Such a comparison to the dominant social group has not been limited to disabled individuals. For instance, Tavris (1992) argues that women are often measured against an idealised male norm, while Hunt’s (1966, 152-3) words offered at the beginning of this section draws a connection between disablism and racism. However, Hahn (1988, 26) argues that, unlike other minority groups:

> [D]isabled men and women have not been able to refute implicit or direct accusations of biological inferiority that have often been invoked to rationalize the oppression of groups whose appearance differs from the standards of the dominant majority.

Thus the rejection of this tendency to use such biological or physiological standards as a means of legitimising the oppression of disabled individuals is an ongoing effort within disability studies.

Another example of how certain discourses and social practices may be taken for granted can be found in medical sociology. Like the previous example, medical sociology treats disability as a problem. However, unlike medical professionals, who study disability as a medical issue confined to the body, medical sociologists are interested in analysing human behaviour regarding disability and the social forces related to it (Matcha 2000, 6). As discussed in the previous chapter, this is done by treating disability as a form of deviance, with medical sociologists viewing disability through a "social deviance lens" (Linton 1998, 533; Thomas 2007, 4). This influences the manner in which the medical sociologist understands disability, often taking it for granted as a social problem, which in turn influences the manner in which medical sociologists approach it as an area of inquiry.

Once again this tendency to treat deviancy as a "natural" attribute of disability has been challenged within disability studies. This has been done by using detailed personal accounts of the experiences of disabled individuals, showing how disability is not just a pathological or deviant state but also an idea that may be interacted with in a variety of ways (Abberley 1987; Barnes and Mercer 1996; Finkelstein 1980; Oliver 1990). Thus, disability studies rejects the formulation of disability as being a matter of social deviance, treating it rather as a social phenomenon constituting a variety of cultures, metaphors and issues (Linton 1998, 526).

The emphasis on critically analysing the discourses and social practices that surround disability shown in the last two examples has allowed contributors to

disability studies to challenge understandings that are often taken for granted within the medical approach. This challenge to such understandings means that different understandings of this social phenomenon to be produced, reproduced, or challenged in a manner that goes beyond the scope of the social deviance lens or medical understandings of the body. As a result, disability studies allows disabled individuals to interact with the terms of their disability in new ways that may have otherwise been restricted within the medical approach. This has led to the argument that "disability studies introduces a disability reading to a range of subject matter" (Linton 1998, 518).

This section has discussed the manner in which disability studies critically analyses traditional understandings and attitudes towards disability, rejecting the restrictive discourses and social practices that contribute to disablism (Thomas 2007, 49). Assumptions that have been taken for granted within the medical approach are interrogated, with an emphasis on how such assumptions formulate the disabled object in particular ways that are then presented as referring to the "true" nature of disability (Weeks 1982, 111). This has led to new understandings of disability, which in turn lend themselves to new approaches to analysing disability, the social forces that relate to it, and the manner in which these social forces may influence the experiences of disabled individuals. This new approach to disability is clearly evident in the social model, which will be discussed in the following section.

The Social Model of Disability

The social model of disability opposes the individual model and the personal tragedy account, challenging the assumption that disability is an issue limited to the body of the individual. Rather, the social model argues that social forces such as the economy, the structural design of buildings, and public stereotyping are key contributors to the experience of being disabled (Barnes *et al*. 1999, 27). Thus, the social model argues that, rather than being a personal problem to be coped with by disabled individuals, disability is a social problem that may be dealt with through social change, rather than through medical intervention, hence the usage of the title "social model".

The fundamental characteristic separating the social model from the individual model is its understanding of disability, which is defined by the Union of the Physically Impaired Against Segregation (UPIAS 1976, 3-4) as:

> The disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities.

In contrast to the individual model, which situates disablement as being an issue confined to the impaired body, this definition implies that disablement has "nothing to do with the body" (Oliver 1990, 4). Rather, disability is represented as a social entity that consists of a wide range of social and material conditions which all contribute to the experience of "disablement" (Bowe 1978).

Factors such as education, support and housing may present a variety of "disabling barriers" for the impaired individual (Barnes *et a*l. 1999, 123). These disabling barriers are not fixed and thus the experience of disability may vary depending on how social or material circumstances relate to the nature of impairment involved. For example, an individual who uses a wheel-chair because of a physical impairment may be able to manoeuvre through their house quite easily owing to the layout of the building, thereby minimising their experience of disablement. However, when this individual leaves the house to go to the movie theatre, which has numerous staircases and no elevator, the experience of disability is increased. This in turn may lead to the impaired individual choosing not to go to the theatre at all, thereby contributing to what the individual model refers to as a social handicap or participation restrictions.

This understanding of disablement occurring on a spectrum based on social circumstances and the environment signifies a radical change from the medical approach and the individual model. Rather than being the result of the impaired individual's biological or physiological condition, disability is repositioned as "the outcome of an oppressive relationship between people with … impairments and the rest of society" (Finkelstein 1980, 47). This "relationship" is significant, as it describes an impaired individual who actively engages with the social and material environment, rather than a passive object of professional attention.

Along with this new understanding of disability the social model offers an alternative approach to assessing disability. The focus in this new approach is on

"disabling barriers and attitudes", rather than personal biological or physiological abnormalities and the subsequent limitations that they may cause (Barnes *et al*. 1999, 28). By comparing this alternative approach to that used by the Office of Population Censuses and Surveys (OPCS), Oliver (1990, 7-8), gives a number of examples of how this new method may be used to assess and question the notion of disability:

> 1 OPCS: "*Can you tell me what is wrong with you?"*
>
> Oliver: "Can you tell me what is wrong with society?
>
> 2 OPCS: "*What complaint causes your difficulty in holding gripping or turning things?"*
>
> Oliver: "What defects in the design of everyday equipment such as jars, bottles and tins causes you difficulty in holding, gripping or turning things?"
>
> 3 OPCS: "*Are your difficulties in understanding people mainly due to a hearing problem?"*
>
> Oliver: "Are your difficulties in understanding people mainly due to their inability to communicate with you?"

This approach is at odds with the ICIDH mode of categorising impairment as the cause of disability and handicap – or in the case of the ICIDH-2 "activity limitations" and "participation restrictions" – that is utilised by the individual model. That is, this approach represents such limitations and restrictions, rather than being caused by individual impairment, as being applied "on top of" the impairment by social organisations (UPIAS 1975, 3-4). This rejection of the ICIDH mode of categorising has led to a firm distinction between impairment and disability within the social model literature, with the link between areas of

medical attention and areas concerning the social environment suggested by the ICIDH-2 being abandoned (Barnes *et al*. 1999, 27-8).

This new approach to the question of disability focuses on external, rather than personal forces. As such, this method of assessing disability draws attention to the effects of the physical, social and economic disabling barriers that may confront individuals living with impairments (Barnes *et al*. 1999, 30). An important characteristic of this new approach is the fact that it allows the social model literature and disabled individuals to reject the personal tragedy approach, which has "served to individualize the problems of disability and hence leave social and economic structures untouched" (Oliver 1986, 16).

One effect of this rejection of the personal tragedy approach and the authority of the medical profession regarding disability has been an increase in the contributions being made to the disability studies literature by individuals with impairments and others outside of the medical profession. For example, the Union of the Physically Impaired Against Segregation (UPIAS) has been influential, offering definitions that have been referenced by contributors to disability studies (Barnes *et al*. 1999; Rapley 2004; Shakespeare 1998). This is significant, since in the individual model such authority and influence is often reserved for medical experts. Furthermore, a number of prominent supporters of the social model are themselves impaired, providing personal insights to an area that is often treated as an object of analysis by disinterested professionals and academics. Chappell (1996, 217) comments that this has added an extra political dimension to

disability studies reflecting the feminist principle that personal experience does not take place in isolation from wider social and political structures.

To summarise the social model's conception of disability, it rejects the individual model's tendency to identify impairment as the determining factor in explaining disability and the limitations associated with it (Oliver 1990). It argues that disability is no more than "a form of disadvantage which is imposed on top of one's impairment, that is, the disadvantage or restriction of activity caused by contemporary social organization that takes little or no account of people with physical impairments" (UPIAS 1976). As such, within the social model impairment is not considered to be a sufficient condition for disability. Likewise, disablement is not a necessary consequence of impairment (Tremain 2001, 630).

Criticisms: Impairment

Similarly to the individual model's definition, impairment is taken to be "nothing less than a description of the physical body" (Oliver 1990, 4-11). Impairment may be due to "the lack of a limb or part thereof or a defect of a limb, organ or mechanism of the body" (UPIAS 1976). In regard to this definition the social model of disability is still informed by the medical profession in its conception of the body as being impaired or non-impaired. This has led to a number of similarities between the social model and the individual model of disability.

For example, while the social model's distinction between impairment and disability may shift the focus of disability away from the body and toward other social factors, thereby opposing the assumptions of the individual model, it still leaves impairment under the exclusive jurisdiction of the medical profession (Hughes and Paterson 1997, 330). This is evident in the fact that the social model defines impairment exclusively in relation to specific bodily characteristics that are distinct in their properties from other physical features, such as race and gender (Chappell 1996, 214). Abberley (1987, 7) argues that this is because the biological characteristics of impairment are more "real" than such things as race and gender, due to the fact that impairment, by definition, implies a functional limitation, whilst race and gender do not.

While the social model argues that disablement is not a necessary consequence of impairment, and impairment is not a sufficient condition for disability, impairment remains a necessary condition for disability (Tremain 2001, 630). As with the individual model, this understanding is informed by medical conceptions of what constitutes the "normal" body. Hence, while it may challenge the notion of disability, the social model accepts the medical knowledge that constitutes conceptions of the impaired and non-impaired body (Barnes and Mercer 1996, 70). This has led to a number of critical responses to the social model within the disability studies literature.

The first criticism deals with the social model's emphasis on the distinction between impairment and disability, with disabling barriers restricting the abilities

of the impaired individual. This notion of disability occurring on a spectrum that may be augmented or diminished by particular social conditions is fundamental to the social model. However, it has been argued that the rearranging of social and environmental conditions does not hold the same enabling ramifications for all impaired individuals (Crow 1996). While such disabling barriers may restrict the opportunities that are made available to an individual with an impairment, it has been argued that the experience of being impaired is a constant part of everyday life that may not be entirely dealt with through social manipulation (Crow 1996).

Furthermore, different types of impairments – be they physical, sensory, or intellectual – have different ramifications for the idea of disabling barriers and how best to deal with them. For example, while the individual who uses a wheel-chair may be able to attend the movie theatre thanks to the presence of an elevator, their intellectual impairment may inhibit the ability to understand the complex plots of certain movies. Suffice to say that the obstacles facing impaired individuals are not always generated by the environment, but are inextricable aspects of their impairment (Shakespeare & Watson 2002, 17).

This argument springs from the accusation that the social model generalises impairment by attempting to use it as a catch all term for all impaired individuals. Chappell (1996, 211-12), argues that this generalisation is a consequence of the social model's rejection of the individual model's tendency to separate and categorise impaired individuals. In the individual model, people with physical, sensory or intellectual impairments are classified by the medical profession and

then dealt with separately regarding their disability and subsequent treatments (Barnes *et al*. 1999). This allows for a wide range of classifications in order to deal with impairments that have little in common with one another. For example, while quadriplegia, blindness, and autism may all be referred to as impairments, they each mean very different things for the individual living with such impairment. Unlike the individual model, however, the social model tries to encompass the living experiences of all individuals facing disabling social barriers. This has resulted in a much more general usage of the term "impairment" (Chappell 1996, 213).

By generalising impairment in such a way, it has been argued that the social model has conflated the particular and experiential differences that may occur within such a broad term. One consequence of this that has been noted within the disability studies literature is the argument that the social model marginalises certain groups (Chappell 1996). For example, while the social model is intended to deal with both physical and intellectual impairment collectively under the general term of impairment, intellectual impairment as an area of analysis remains heavily under-theorised in comparison to that of physical impairment (Chappell 1996).

This under-representation of the intellectually impaired is reflected in the lack of contributions that deal with this area within the social model literature. Likewise, the contributions that are made to the social model which deal with the empirical experiences of individuals are almost exclusively concerned with impairments

confined to the body (Chappell 1996, 217). Finally, while many contributions have been made by impaired individuals, thereby adding personal insights into the experience of impairment and challenging the dominance of the medical professional, there is yet to be any significant contribution to the literature from intellectually impaired individuals (Chappell 1996, 217).

In regard to the under-theorisation of intellectual impairment in works associated with the social model, Carlson (2010) argues that this realm of inquiry is marginal because concerns about intellectual impairment are not pressing. She suggests that, in regard to representation: "the intellectually disabled are not persons. They are owed respect and justice only by virtue of their relationship to non-disabled family members who *are* persons" (Carlson 2010, 2.). While the physically impaired are able to directly contribute to the social model literature, adding personal insights into the experience of physical impairment, this is often not the case for intellectually impaired individuals, who may need others to speak for them.

Hence, while the social model may empower impaired individuals by challenging conceptions of disability and the personal tragedy model, this empowerment is not evenly distributed, nor is it made available to all impaired individuals. Rather, it is often limited to those with physical impairments, while intellectually impaired individuals are included only by virtue of falling into the general category of impairment (Chappell 1996, 214). This has contributed to the

argument that intellectual impairment is neglected within the social model literature.

This neglect is due in part to the social model's tendency to use medical conceptions that position the body as the site of impairment. For example, in referring to the apparent opposite of the impaired individual, Swain *et al*. (1993) often employ the term "able bodied". Likewise, Barnes *et al*. (1996, 43) refer to the "myth of bodily perfection" in their critique of the individual model. Furthermore, Crow states that "impairment means the experience of our bodies can be unpleasant or difficult" (1996, 209). In each of these examples the arguments being made are reserved for those with physical impairments, with no mention of the possibility of an "able bodied" intellectually impaired individual.

The emphasis on the body in the social model has been critiqued owing to the fact that, as Chappell (1996, 214) states in her description of intellectual impairment:

> [T]he body is not the site of the impairment: the impairment may not be immediately apparent and nor may it be associated with any physical imperfection.

While the body may be referred to directly in discussing the cause of physical impairment, this is not the case with intellectual impairment. The term "physical impairment" is implicitly linked to physical characteristics, with intellectual impairment suggesting something else entirely, as Jensen's (1998, 336) description of intellectual impairment, referred to as "mental retardation" shows:

> Mental retardation is, rather, a thinking disability, and intelligence is synonymous with thinking. Although it is possible to educate mentally retarded persons and to train them to perform many tasks … we do not yet have the means of raising their general level of intelligence.

To summarise, the social model of disability treats disability as a social issue that may be dealt with through social and environmental manipulation. In so doing, the social model rejects the individual model's tendency to treat disability as a personal problem, arguing that disability is not a necessary consequence of impairment, and that impairment is not a sufficient condition for disability (Tremain 2001, 630). However, impairment remains a necessary condition for disability, with disabling barriers being a problem to be faced by individuals because of their impairment, rather than such things as their race or gender (Tremain 2001, 630). Thus, impairment is maintained as a biological and physiological issue that is at odds with the "normal" body. In this way the social model maintains the medical tendency to position the body as being the site of impairment (Hughes & Paterson 1997, 330). This has led to criticisms regarding the social model's emphasis on disabling barriers and general use of the term impairment, with some writers arguing that the social model has marginalised certain groups by attempting to use "impairment" as a catch all term (Chappell 1996, 213-14).

Conclusion

This chapter has offered an overview of the social approach to disability, which treats disability as a social issue, with social forces having a direct relation to experiences of disability. The social approach has been influential within disability studies, which argues that oppressive social structures exacerbate experiences of disability. This leads to the argument that disabled individuals represent an oppressed social group. Disability studies rejects this oppression, offering a critical analysis of taken for granted understandings of disability that may contribute to the experience of disability.

The social model of disability represents the "big idea" of the social approach and disability studies. This model distinguishes between impairment and disability, arguing that impairment serves as a description of the body, while disability has nothing to do with the body. The thesis concluded its discussion of the social approach with an analysis of a number of criticisms that have arisen in response to the social model, particularly in regard to its general use of the term impairment, as well as its tendency to focus primarily on the physically impaired, rather than those with intellectual impairment.

CONCLUSION

The thesis has offered a descriptive analysis of scholarly interest of an area of inquiry comprised of a wide variety of understandings and practices. The medical approach treats disability as a pathological state caused by biological and physiological dysfunctions. This means that disability is understood as a personal problem that is confined to the body of the individual. In contrast, the social approach treats disability as occurring on a spectrum that is intimately connected to social forces that increase or decrease experiences of disability. As such, the social approach understands disability as being a social issue characterised by a range of social and material conditions.

In describing these two approaches the thesis has shown that there are numerous ways in which disability may be understood and that this in turn influences the manner in which it is discussed and treated as an area of inquiry. This is exemplified in the description of the different fields have been informed by these approaches. Medical sociology has been influenced by the medical approach in its tendency to view disability through a "social deviance lens", with disabled individuals being treated as a group that deviates from the biological, physiological standards set by the medical profession (Thomas 2007, 4). Disability studies, on the other hand, treats disability as a form of social oppression, with disabled individuals being subject to disabling barriers that exacerbate their experiences of disability (Linton 1998, 525-6).

These approaches are also intimately related to the language, categories and modes of measurement that are used in dealing with disability. The individual model of disability focuses on bodily abnormalities, using medical understandings of the body in order to measure disability based on functional limitations and deficiencies. This is supported by a distinction between impairment, disability, and handicap, with impairment describing a biological or physiological dysfunction, whilst disability and handicap describe the consequences that this dysfunction may have on the life of a disabled individual (WHO 1976, 28). The social approach distinguishes between impairment and disability, arguing that impairment serves as a description of the body, while disability has nothing to do with the body. In line with this distinction is the argument that impairment need not lead to disability, with disability being a form of social disadvantage that is applied on top on an impairment (UPIAS 1975, 3-4).

These understandings are not limited to the approaches discussed in the thesis and often overlap in various ways. Nevertheless, it remains the case that there are a number of important differences that separate the medical approach from the social approach. The thesis has described these differences whilst adhering to Bauman's four important traits of sociological thought: *Responsible speech, size of the field, making sense,* and *defamiliarisation* (Bauman 1990, 12-15). In so doing, the thesis has made no normative claims and avoided advocating one approach over another, presenting the information in such a way to defamiliarise any assumptions or understandings surrounding disability that may have been taken for granted.

In closing, the medical approach and the social approach to disability represent two different ways in which disability may be approached as an area of inquiry. These approaches each have different understandings and practices to offer, and by becoming familiar with both of them one may better understand the different ways in which disability may be viewed as a medical and social issue. While the thesis acknowledges that the descriptions offered here reflect just a portion of such understandings and practices, this does not detract from the fact that the medical model and the social model have been influential in informing the different ways in which disability may be understood and analysed: a fact that has been demonstrated here.

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